

# Triage Guidance for CV Procedures

## Preamble

Distributed by: Mary Osborne, System Director Cardiovascular Service Line

The information contained herein is being provided as examples and general guidelines to be considered by CommonSpirit Health providers and teams. The treating physician is the ultimate decision-maker on the appropriate timing for the procedure. The entire situation, including the presence of COVID-19, availability of personal protective equipment and beds and local conditions should be considered.

COVID-19 is a quickly evolving public health emergency. The information provided in this document does not supersede relevant guidance from the Centers for Disease Control and Prevention, state and local health authorities, and your organization's mitigation and response plan.

## Cardiac Surgery

	Elective 	Urgent 	Emergent 
<b>Guidance</b>	American College of Surgeons: Medical need determined by the cardiac surgeon along with logistical feasibility (beds, staff, equipment, supplies, and provider and community well-being).		

## Interventional/Structural Heart

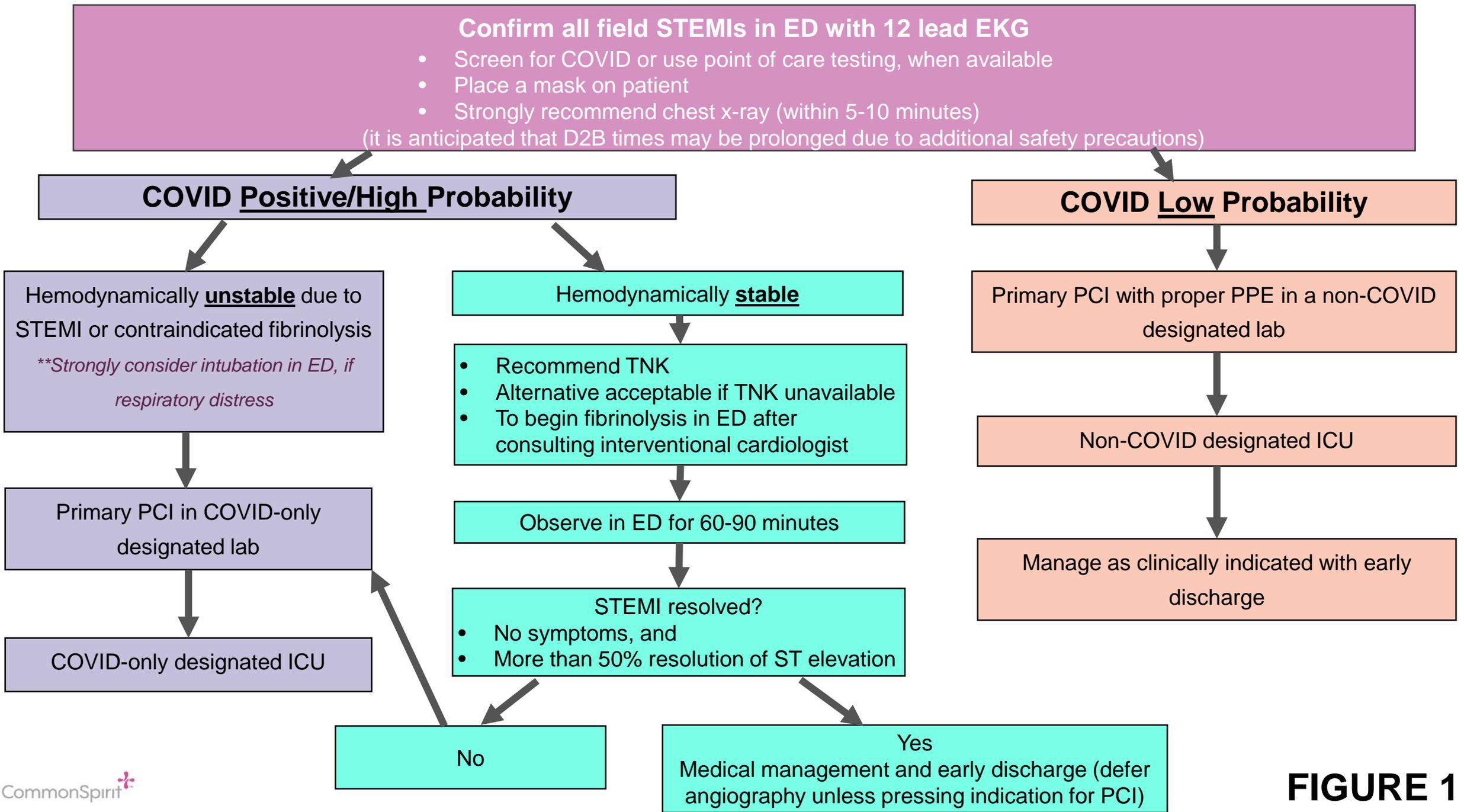
	Elective 	Urgent 	Emergent 
<b>Guidance</b>	<p>The American College of Cardiology Interventional Council and Society of Cardiovascular Angiography and Intervention produced a joint statement outlining considerations for issues facing catheterization laboratory personnel during this pandemic. The statement outlines considerations for Elective Patients, NSTEMI patients and STEMI patients. In addition, CommonSpirit Health and a subgroup of its interventional cardiologists have included algorithms to support decision making in active or suspected COVID-19 patients with STEMI and out of hospital cardiac arrest. See Figures 1, 2 and 3 on the following pages.</p> <p>It is expected there are exceptions to these general rules driven by the patient's age, comorbidities, clinical presentation and the provider's clinical judgement, which may warrant an upgrade in the category of a specific procedure from being elective to being urgent or emergent based on unique circumstances. Providers shall state in the medical record and the procedural note the rationale for the timing of the procedure.</p> <p>The American College of Cardiology provided additional guidance, which includes not only procedures, but diagnostic testing at <a href="https://www.acc.org/latest-in-cardiology/articles/2020/03/24/09/42/general-guidance-on-deferring-non-urgent-cv-testing-and-procedures-during-the-covid-19-pandemic">https://www.acc.org/latest-in-cardiology/articles/2020/03/24/09/42/general-guidance-on-deferring-non-urgent-cv-testing-and-procedures-during-the-covid-19-pandemic</a></p>		

## Electrophysiology

	Elective 	Urgent 	Emergent 
<b>Guidance</b>	<p>Due to the impact of COVID-19 cases on healthcare resources, including hospital beds, PPE, and increased risk to patients and healthcare providers through contact with individuals who are infectious, hospitals and practices should follow CDC recommendations to postpone elective EP procedures. The Heart Rhythm Society recommends the following as a best practice: Elective procedures may include, but are not limited to, ablation in clinically stable patients, device upgrades, most primary prevention ICD implants, left atrial appendage closure device implants, and implantable loop recorders. Read more at <a href="https://www.hrsonline.org/COVID19-Challenges-Solutions/Message">https://www.hrsonline.org/COVID19-Challenges-Solutions/Message</a></p> <p>The American College of Cardiology has provided more complete guidance, which includes diagnostic testing at <a href="https://www.acc.org/latest-in-cardiology/articles/2020/03/24/09/42/general-guidance-on-deferring-non-urgent-cv-testing-and-procedures-during-the-covid-19-pandemic">https://www.acc.org/latest-in-cardiology/articles/2020/03/24/09/42/general-guidance-on-deferring-non-urgent-cv-testing-and-procedures-during-the-covid-19-pandemic</a></p> <p>Decisions about what tests/procedures to perform (or not perform) should be based on the patient's age, comorbidities, clinical presentation and the provider's clinical judgement. Providers shall state in the medical record and the procedural note the rationale for the timing of the procedure.</p>		

## Transplant/LVAD

	Elective 	Urgent 	Emergent 
<b>Case Types (Examples)</b>	<ul style="list-style-type: none"> <li>• Telemedicine/Telehealth visits</li> </ul>	<ul style="list-style-type: none"> <li>• LVAD INTERMACS Class 3- Inpatient or Outpatient, local decision</li> </ul>	<ul style="list-style-type: none"> <li>• Transplant</li> <li>• Temporary MCS</li> <li>• LVAD INTERMACS Class 1 and 2</li> </ul>



**FIGURE 1**

# Out of Hospital Cardiac Arrest

Resuscitated successfully with STEMI

No role for fibrinolysis

Confirm COVID status, if possible

Thoughtful Pause

(to assess the overall risk and benefit of PCI versus conservative medical management on a case by case basis)

Medical Management

PCI

**FIGURE 2**

# Thoughtful Pause

## Emergency Room Cath Lab Activation Process

*Rationale: This process is designed to facilitate effective decision-making on patients with STEMI without adding significantly to D2B time.*

Most patients will be taken to the cath lab as quickly as possible. The only exceptions will be in the subset of patients in whom the benefits of primary, emergency PCI are unclear. In these circumstances, the cath lab will be activated as usual, but the patient will be held in the ED until the Interventional Cardiologist on-call has the opportunity to evaluate the patient in the ED.

<b>Do not Activate Cath Lab</b>	<b>Discuss with Interventional Cardiologist before proceeding to Cath Lab</b>	<b>Activate STEMI</b>
<ul style="list-style-type: none"><li>• Patients with obvious comorbidities that limit life expectancy to &lt; 6 months</li><li>• Pre-determined not a candidate for heroic measures (i.e. Advanced Directive or end stage dementia)</li></ul>	<ul style="list-style-type: none"><li>• Patient post arrest with &gt;10 minutes of downtime without resuscitation or unwitnessed</li><li>• Patients over age 85</li><li>• Patients who have already received fibrinolytic therapy</li><li>• Patients with symptom onset &gt; 12 hours prior to arrival in the ED</li><li>• Patients with questionable pre-event functional status and ability to return to effective functional status</li><li>• Known metastatic cancer</li></ul>	<ul style="list-style-type: none"><li>• No contraindications as listed in the previous columns</li></ul>